DEBATE

Peter F. Lawrence, MD, Section Editor

Single-specialty versus multispecialty vascular surgery group model

Christopher L. Wixon, MD,[a] **Krishna M. Jain, MD,**[b] and **Bhagwan Satiani, MD, MBA,**[c] *Savannah, Ga; Kalamazoo, Mich; and Columbus, Ohio*

The shift in employment options for vascular surgeons in the current era of major health care reform is being widely debated. After the decision to seek hospital employment or independent practice, the choice of then practicing in a single-specialty or a multispecialty practice remains a difficult decision. Although the trend is toward medium-sized to large-sized groups, only 1.2% of medical practices currently have >11 physicians. Barring the large multispecialty groups, such as Kaiser Permanente, Cleveland Clinic, or Mayo Clinic, most vascular practices are constituted as small groups. Which format prospers will depend on adroit management of financial and intellectual capital and nimbleness in adapting to rapidly changing market conditions. In this report, two practicing vascular surgeons debate the merits of single or multispecialty practice, with a commentary to follow. (J Vasc Surg 2013;57:1698-702.)

For new graduates, the choice between a single-specialty or multispecialty practice is difficult. This debate between the proponents of each format should assist new and established vascular surgeons in making the decision somewhat easier. It must be emphasized that because no data are available to compare the efficiencies of the single-specialty vs multispecialty practice, the arguments are based on personal experience only.

THE CASE FOR SINGLE-SPECIALTY PRACTICE

Christopher L. Wixon, MD, *Savannah, Ga*

In today's environment of declining reimbursement and increasing expenses, many physicians are critically reevaluating their practice model and administrative structure. Since 2005, the number of independently functioning practices has declined from 50% to 33%—a trend that will likely continue as physicians seek financial refuge of larger entities with broad-based financial resources.[1]

Although partnership with a hospital system remains a significant factor in the multitude of practice arrangements, the choice of a single-specialty practice or multispecialty practice remains an independent consideration. The decision becomes a matter of choosing the preference that will best achieve the physician's long-term professional and financial goals after considering the financial, operational, strategic, and corporate structure of the organization.

A point of view in support of the single-specialty vascular practice will be illustrated by pointing out the collectivism mentality, loss of professional autonomy, loss of nimbleness related to large size, potential risk of fee sharing with other specialties, and the administrative complexities imposed by multispecialty groups.

The collectivism of multispecialty practice. A multispecialty practice is a collective effort of physicians of varying expertise, work ethic, and experience working in a concerted effort to produce a product at a more effective cost, the savings of which may be enjoyed by the collective multispecialty body. The arrangement stresses the goals of group practice over goals of the individual practitioner and represents a form of vertical collectivism. Although acknowledging that members may be different from each other, emphasis is placed on interdependence rather than on individualism.

The collective mentality is often justified by focusing upon the "welfare of the patient," "group outcomes," or "benefit to a community"—all noble endeavors, but of secondary consequence to the needs of the individual physician. Leaders of multispecialty practices often rise to power on a groundswell of accretive rhetoric that promises the whole being greater than the sum of its individual parts. Proponents of multispecialty practice often emphasize the growing difficulties that individual physicians and small practices will face in a tumultuous health care environment.

From Savannah Vascular Institute, Savannah[a]; Advanced Vascular Surgery, Kalamazoo[b]; and The Ohio State Heart and Vascular Center and the Ohio State, University Medical Center, Columbus.[c]

Author conflict of interest: none.

Reprint requests: Bhagwan Satiani, MD, MBA, Division of Vascular Diseases & Surgery, Medical Director Vascular Labs, 376 W 10th Ave, #701 Prior Hall, Columbus, OH 43210 (e-mail: bhagwan.satiani@osumc.edu).

The editors and reviewers of this article have no relevant financial relationships to disclose per the JVS policy that requires reviewers to decline review of any manuscript for which they may have a conflict of interest.

0741-5214/$36.00

http://dx.doi.org/10.1016/j.jvs.2012.12.045

Fellow physicians, there is great allure in altruistic notions but also great danger. You have dedicated a career to serving individuals with vascular disease, would you likewise place the needs of an organization above your own?

Size matters. The American marketing machine has successfully confused the notions of quantity and quality. We have come to know these disproportionately large items as "super-sized" or "value-sized," creating an expectation that mergers are accretive; that is to say, we expect economies of scale to be the necessary output from increasing size. However, sound decision making requires objectivity beyond the evident, and simply being BIG is not a sufficient argument. Without doubt, strength, size, and power are indeed attractive qualities, but often come at the expense of speed, agility, and maneuverability.

In the case of a single-specialty practice, where scope of services is limited, increasing size will almost certainly yield increased specialization, expertise, and efficiency. However, if the size increases as a result of expanded scope of services, such as occurs with a multispecialty practice, this will yield decreased specialization and expertise and reduced efficiency. As Hough et al[2] point out in a comparison of single-specialty vs multispecialty practices, surgical subspecialties, in contrast to primary care, do have advantages related to productivity and increased revenue, provided they are not solo or two-physician practices.

Fee sharing. The group offering primary care functions in an environment that is labor-intensive and facility-intensive, resulting in a practice overhead that consumes almost 60% of total revenues.[3] As costs of providing care continue to rise, primary care physicians struggle to remain solvent. Their principal value seems to lie more in their referrals for expensive hospital and specialist care than in anything that they themselves are able to provide. The multispecialty practice model has been formulated as a means to broker a deal to stop the bleeding. Multispecialty practices pursue ancillary services with the promise that the integrated group will use profits to support primary care. If such endeavors do not prove adequate, the administrators can further shave off the salaries of the specialists and redirect dollars to pay higher salaries to the primary care network.

A 2009 survey found that specialists working in multispecialty practices earned 19.85% less in total compensation.[4] Primary care physicians working in multispecialty practices reported total compensation of $12,000 more than their colleagues working in independent practices. Put simply, multispecialty practices need specialists to balance the lower revenue and higher overhead of the primary physicians (Table).[5]

There is no shame in hard work and certainly no shame in being compensated fairly for one's effort. We have trained for years, perform procedures that are technically and physically demanding, and our burnout rate is high.[6] Rest assured that the income that you generate is hard earned.

The risk of loss of professional autonomy. Concentrating power causes significant risk because decisions that no man would dare consider for his own selfish sake are perpetuated with a clear conscience by the altruists who justify themselves by the common good. Necessarily, a multispecialty practice results in the empowerment of a minority of individuals in the name of some ideal, such as "patient-driven outcomes." Therefore, there is some risk in a multispecialty network of a few individuals in one specialty or another to concentrate power and justify themselves by the common good.

Table. The language of multispecialty groups[a]

Multispecialty groups say. . .	*. . . What they mean*
For the good of the group . . .	Socialize income for the group
Economy of scale	Co-mingle expenses
Mitigate risk	Limit upside potential
Optimize administrative and financial resources	Create layers of corporate infrastructure

[a]Source: Satiani B et al.[5]

Referrals network. Perhaps the greatest benefit purported by a multispecialty practice is the built-in referral base. However, the multispecialty practice specialist may suffer from limited referrals from outside the practice. If the group is only able to support one or two specialists in a given field, call-coverage problems and professional alienation may occur. Finally, because referrals are made based on a financial relationship rather than on quality medical care, the physicians are not forced to perform at their best. Ultimately, patient outcomes, one of the very pillars upon which the multispecialty practice was founded, begins to deteriorate.

Incremental administration. There is little doubt that the increased accounting and administrative requirements of a multispecialty practice entail some risk. Accrual accounting methodology, a single tax identification number, and a central payment posting office that must process a single explanation of benefits containing payment for multiple providers provides multiple opportunities for previously unrecognized costs and errors. Autonomy and decision-making ability decrease as the group grows in size, and larger practices become bureaucratic and policy-driven. Clashes between physicians over referrals, commercial contracts, working hours, and relative compensation may cause conflict.

THE CASE FOR MULTISPECIALTY GROUP

Krishna M. Jain, MD, *Kalamazoo, Mich*

Various models are available to a vascular surgeon who wishes to start practicing after finishing a fellowship in vascular surgery, including solo practice, single-specialty group practice, multispecialty group practice, hospital-based practice, or academic university practice.

What follows is the case for multispecialty groups by discussing the organizational setup needed to establish the group and then pointing out the advantages related to the economies of scale, relationships with hospitals, and access to capital and to a large referral base.

Group size. Although the optimal size has not been clearly defined, Marder and Zuckerman[7] applied survival analysis and concluded that the least efficient practices will fold, and only large multispecialty group practices may be of optimal size and survive. In addition to profitability measures, coordination of patient care and "branding" are important advantages of multispecialty groups.[8] The solo practice is in severe decline. Between 1996 and 1997 and 2004 and 2005, the proportion of physicians in solo and two-physician practices decreased from 40.7% to 32.5%.[9] The trend continues to be in favor of hospital-based practice.[5] Short of being hired by the hospital, one could join a multispecialty group and reap the benefits provided by a large group consisting of different specialties.

The first model of a multispecialty group practice was the Mayo Clinic model started in the late 19th century. Multispecialty groups could be owned by the hospital, work in a foundation model with the hospital, or be independent of the hospital. The data on physician-owned groups are scant. It is believed that close to 25% of all doctors or approximately 200,000 physicians could be working in various models of multispecialty groups.[10] This section deals with multispecialty physician-owned groups and not the likes of large organizations like Kaiser Permanente or Cleveland Clinic.

Organizing a multispecialty group. The fundamental basis for organizing the group is to have like-minded doctors working together. As the group gets bigger and more diversified specialties are incorporated in the group, legal issues related to anti-kickback and Stark laws become a hurdle. Salient features of the Stark Law relevant to multispecialty groups that need expert legal advice are (1) overhead expenses and income must be distributed based on prospective methodology, (2) the board makes the decision on budget and salaries, (3) no physician shall be paid based on the volume or value of referral, and (4) the profit and loss of "designated health services," such as clinical laboratory services, radiology and imaging, and in-patient and out-patient hospital services, shall be divided equally between the partners in the group and not based on the volume of referrals.[11] The law is very comprehensive, and before undertaking any ancillary service venture, one must consult an attorney specializing in Stark Law.

The governing board has the authority to decide how the physicians will be compensated. Any number of ways can be used to reimburse the doctors. In our group, each division or pod of the multispecialty group is given the authority to divide the revenue in that division as the division sees fit. Some divisions divide money equally among partners and some do it on the basis of productivity.

Benefits. It is becoming difficult for a new doctor to go into a solo practice. The combination of student loans and the start-up cost of a practice pose serious challenges. Close to 50% of medical students are women, and they can have better working hours, a collegial environment, and guaranteed income in a group practice. There is evidence that organized care by multispecialty groups can decrease the cost of providing health care.[12] In a group of several specialists and primary care physicians, a phone call to a partner can avoid a lot of unnecessary tests. Easy access to each other's patient records can avoid duplication.

Administration. The Achilles' heel for any doctor's practice is managing the practice. There are >100,000 pages of Medicare law alone to comprehend. Central administration can take care of all the hassles related to managing a practice. The office can negotiate contracts for malpractice insurance, various third-party contracts, health insurance, and information technology contracts. It can manage accounting, pension, and legal requirements. It can create a policy manual for employees and perform the human resource function. It can carry out other activities such as managing workman's compensation, payroll taxes, and a line of credit.

Economies of scale. The bigger and more diverse the group in specialties, the more clout the group has to negotiate contracts with third-party payers. On the expense side, contracts for malpractice insurance, health insurance, and disposable goods can be negotiated at better than the market rates. Billing can be combined. There can be a significant price break in buying and maintaining an electronic health record system.

Hospital interaction. Once the group speaks with one voice, the hospitals are much more willing to work with various specialties represented in the group. The group protects individuals and individual specialties if the hospital decides to take an adverse action toward one of the units of the group. A group environment also gives better opportunity to partner with the hospital on various projects to improve patient care and the financial well-being of the hospital and the group.

Overhead expense. By combining various functions in the central office, the overhead expense comes down. Because reimbursement is decreasing, controlling cost is the only way physicians can have an adequate income. There is nothing on the horizon that would increase reimbursement in any meaningful way.

Capital projects. The group can embark on large projects because of risk sharing and better capital access because of the size of the group. Electronic health records or a new building or designated health services can be undertaken because the group has the resources and tools to do it.

Referral base. Doctors in a group setting are more likely to refer to each other because they know the quality of care their patients will get. This results in increased referrals that would have gone elsewhere. If some of the members have outreach clinics, a patient from those areas will be referred to you without you having a presence in those geographic areas.

Future. The health care delivery system is in flux. No one knows what the future will look like. A group of doctors representing various disciplines will be in a much stronger position in a local market than a solo practitioner or a single-specialty group. As patient outcomes, quality, and safety become increasingly tied to reimbursement, cooperation between a group of physicians and a health system will be an advantage for multispecialty groups.

REBUTTAL IN FAVOR OF SINGLE-SPECIALTY GROUPS

Informed decisions regarding single-specialty vs multispecialty group practice can only be determined after careful consideration of the advantages and disadvantages of each. A single-specialty practice can be extremely rewarding but can likewise be equally challenging. More than ever, single-specialty practices face substantial pressure to consolidate. Declining reimbursement, rising costs of health insurance, and the need to develop a robust informatics and technology infrastructure are universal to all vascular practices. These pressures will continue to mount unless a fundamental change occurs in the manner of reimbursement.

Although many physicians are seeking administrative efficiency, there is no guarantee that it will be borne of the multispecialty practice, which promises economy of scale. A critical look at multispecialty practices reveals a foundation built on social rather than individual needs. An empowered hierarchy is established by feeble claims of perceived efficiency and whose status quo is maintained by a culture of fear of being left out of the emerging Accountable Care Organization. Although patient-driven outcomes are often cited as the rationale by which multispecialty clinics are established, an honest evaluation of the motivation of the participating physicians will reveal a contrary motivation fueled by insecurity and pretense.

Single-specialty practices embrace the belief that it is desirable for physicians to fully develop their individual talents. As a culture of transparency and consumer-driven data continues to mature, single-specialty practices will be uniquely positioned as the emerging Accountable Care Organizations supplant the commercial insurers as third-party payers. As they seek to contract with physicians with superior outcomes, success will increasingly be based on favorable outcomes rather than on business relationships.

REBUTTAL IN FAVOR OF MULTISPECIALTY GROUPS

The case for single-specialty practice has been laid out by Dr Wixon. In a geographic area where there is no competition, this model may work well because the group has the power to negotiate with insurers and hospitals. In most of the country, however, that may not be the case. There are several points raised that can be challenged.

It is not correct to say of multispecialty practices that, "emphasis is placed on interdependence rather than individualism." In a well-functioning group, every specialist is given a chance to grow at the rate he or she strives for. The group supports the activity. An individual physician's success directly correlates to the group's success. The group looks after every physician's well-being.

The point of view that increasing scope of service will decrease expertise and reduce efficiency is erroneous. If the physicians do not have to deal with the administrative tasks in the individual specialty within the group, efficiency and expertise will increase because the specialist has to support the need of the group's patients and others outside the group.

The biggest issue that a multispecialty group deals with is reimbursement to primary care physicians. It is not mandatory for the group to provide primary care. A large group of doctors in various specialties will always have more clout than a single-specialty group. A single specialty can be replaced much more easily than multiple specialties. Once the group has decreased the overhead for everyone, primary care doctors do not need to be subsidized using various methods of reimbursement.

It is possible that single-specialty group doctors make more money than the doctors in a multispecialty group. However, I firmly believe that if the group is formed only to increase compensation, then the group should not be formed at all. It is not necessary to "create an authoritative structure to be effective." A democratic structure works much better. The board should be elected and represent multiple specialties in the group. Members should regularly rotate in and out. This does not create a dictatorial system.

It is also incorrect that "larger practices become bureaucratic and policy-driven." Policy is important, but bureaucracy is not. A physician should be the president and chief executive officer of the group. The president's position can also be term-limited. If a nonphysician leader is chosen to lead the group, bureaucracy may be the result. In addition, it is inaccurate to say that a multispecialty group does not address individual needs. It depends on how the governance of the group is set up. There is no "culture of fear," as implied by my colleague. It gives every physician in the group courage and strength to meet present and future challenges.

COMMENTARY

Bhagwan Satiani, MD, MBA, *Columbus, Ohio*

The format of vascular practices is more than a parochial interest to vascular surgeons. It has national cost, access, and quality-of-care implications.

What is the optimal size of a vascular surgery practice? In economic terms alone, profitability is the ultimate test of "optimal." Profitability, in turn, depends on demand for services and efficiency of productivity of the practice. In reality, however, the decision by a vascular surgeon to join a single-specialty or a multispecialty practice is more than consideration of productivity and compensation alone. Although the future direction of health care reform is uncertain, trends are becoming obvious.

We are clearly trending from small-scale independently run practices to medium-sized to large-sized single-specialty or multispecialty groups. Physicians increasingly are practicing in midsized, single-specialty groups of six to 50 physicians.[9] Of the estimated 161,200 medical practices in the United States, only 1.2% have >11 physicians.[13] The trend toward larger groups and hospital-based employment is particularly striking in younger physicians. A survey of 500 physicians aged <50 years found 58% are employees of a medical group.[14]

In the most current survey of the Society for Vascular Surgery membership, of those vascular surgeons in private practices, only 21.2% were in solo practice compared with 48.3% in a single-specialty group and 30.5% in a multispecialty group. Two-thirds indicated their group size was between two and four physicians.

Single-specialty and multispecialty structures each have advantages and disadvantages. Single-specialty groups coalesce to form a reputation as a high-quality provider, have leverage over health plans, possess capital to invest in equipment and new technology, hire internal professional management, and provide a boost to shared interests, including lifestyle. They have higher compensation, more agile decision making, and avoid complicated governance and management issues inherent in having primary care specialties at the table. The multispecialty model has collaboration and collectivism, a team approach, economy of scale, offers "one-stop" shopping for consumers, better access to capital, protection of referrals, and attractiveness to health plans. In a small pilot study of care provided to Medicare beneficiaries in 22 health care markets by medical groups, multispecialty groups provided higher-quality care at a 3.6% lower annual cost.[15] However, no systematic information on a large scale comparing patient outcome, safety, the cost or quality of care between the two types of groups is available.

In an era of dramatic impending change, the questions are:

- Which model will have the financial capital to expand or deal with competition from hospitals and health systems and have the intellectual capital to prosper?
- Which structure will overcome insufficient retained earnings, inefficient decision making, and slowness in dealing with adjusting to market realities?[16]
- If control of health care costs and coordination of care become the focus of our health care system, which of these models will best accomplish these objectives?

Most groups, whether single-specialty or multispecialty that survive and prosper, will be capital-intensive and labor-intensive organizations that rapidly adjust to market conditions.

Note: Dr Wixon is in a single-specialty private practice, Dr Jain is in a multispecialty private practice, and Dr Satiani was in a single-specialty private practice group for 25 years and is now in full-time academic practice.

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Submitted May 27, 2012; accepted Dec 10, 2012.